CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 432 **Date: JANUARY 14, 2005**

CHANGE REQUEST 2965

SUBJECT: Adding an Indicator to the National Claims History (NCH) to Indicate that DMERCs, Carriers, and FIs have Reviewed a Potentially Duplicate Claim

I. SUMMARY OF CHANGES: This transmittal adds requirements for Durable Medical Equipment Regional Carriers (DMERCs), Carriers and FIs to add an override edit to NCH showing that the contractor has reviewed a potentially duplicate claim, determined it was not a duplicate, and approved it for payment.

NEW/REVISED MATERIAL - EFFECTIVE DATE: July 1, 2005
***IMPLEMENTATION DATE: July 5, 2005**

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/10/120 – Detection of Duplicate Claims

III. FUNDING: *Medicare contractors only:

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Special Notification

Attachment - Business Requirements

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SUBJECT: Adding an Indicator to the National Claims History (NCH) to Indicate that DMERCs, Carriers, and FIs have Reviewed a Potentially Duplicate Claim

I. GENERAL INFORMATION

A. Background: The Office of Inspector General (OIG) has repeatedly criticized the Centers for Medicare and Medicaid Services (CMS) for paying for duplicate claims. In response, CMS commissioned a study to determine why payment of apparent duplicate claims continues to be a vulnerability for the Medicare program. One of the findings of this study was that many items identified by the OIG as duplicates were not, in fact, duplicates but, rather, were previously reviewed for duplication and appropriately paid. The OIG would not have known this based on (National Claims History) NCH data, because there is currently no indication in NCH that would indicate that the contractor had conducted such a review. In order to better assess the actual extent of duplicate claim payment in the future, an indicator will be added to the NCH record when an apparent duplicate claim has been reviewed for duplication and found not to be so.

B. Policy:

Carriers, DMERCs, and FIs

Effective for claims received on or after April 1, 2005, Medicare Carriers, Durable Medical Equipment Regional Carriers (DMERCs), and fiscal intermediaries (FIs) must add an informational indicator to the Common Working File (CWF) transaction record when, as a result of an audit/edit or CWF reject the contractor examines what appears to be a duplicate item or service and approves it for payment. Use the following indicator:

> Value 1: suspected duplicate review performed – service determined not to be a duplicate and is approved for payment

Carriers, DMERCs, and FIs will place the appropriate value in the new indicator field of the HUBC/HUDC/HUOP/HUIP/HUHH/HUHC record. CWF shall pass the indicator to NCH.

Carriers, DMERCs and FIs shall not change their current editing procedures for duplicate claims.

C. Provider Education: None.

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
2965.1	CWF and Standard System Maintainers shall create a new field in the HUBC, HUDC, HUIP, HUOP, HUHH and HUHC for the duplicate value at the detail-line level.					X	X	X	X	
2965.2	The new field created in the HUBC, HUDC, HUIP, HUOP, HUHH and HUHC , shall be named "Suspect Duplicate Review Indicator."					X	X	X	X	
2965.3	CWF shall accept the appropriate "Suspect Duplicate Review Indicator" value in the appropriate HUBC, HUDC, HUIP, HUOP, HUHH and HUHC fields.								X	
2965.4	Carriers, DMERCs, and FIs shall enter a value of "1" when they appropriately approve and pay for an item that was reviewed as a suspected duplicate and determined not to be a duplicate	X	X	X	X					
2965.5	A blank value shall indicate that no suspected duplicate review was performed.	X	X	X	X				X	

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N\A

X-Ref Requirement #	Instructions

B. Design Considerations: N\A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: NCH

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: July 1, 2005 **Implementation Date:** July 5, 2005 **Pre-Implementation Contact(s):** Angie Costello at acostello@cms.hhs.gov for DMERC questions. Yvette Cousar at ycousar@cms.hhs.gov for Carrier questions. Cindy Murphy at cmurphy1@cms.hhs.gov for FI questions. **Post-Implementation Contact(s):** Appropriate RO	**No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

120 - Detection of Duplicate Claims

(Rev. 432, Issued: 01-14-05, Effective: 07-01-05, Implementation: 07-05-05)

Hard Coding of Duplicate

Only exact duplicate edits lend themselves to "hard coding" to prevent a Medicare contractor from overriding a shared system edit. Edits mentioned below may not be user-controlled.

A - Carriers

Exact duplicates for Carriers are as follows:

- HIC Number;
- Provider Number;
- From Date of Service;
- Through Date of Service;
- Type of Service;
- Procedure Code;
- Place of Service; and
- Billed Amount.

B - FIs

Exact duplicates for FIs are as follows:

- HIC Number;
- Type of Bill;
- Provider Identification Number;
- From Date of Service;
- Through Date of Service;
- Total Charges (on the line or on the bill); and
- HCPCS, CPT-4, or Procedure Code modifiers.

C - Additional FI Instructions

Whenever any of the following claim situations occur, the FI develops procedures to prevent duplicate payment of claims. This includes:

- Outpatient payment is claimed where the date of service is totally within inpatient dates of service at the same or another provider. Do not consider outpatient services provided on the day of discharge within the inpatient dates of service.
- Outpatient bill is submitted for services on the day of an inpatient admission or the day before the day of admission to the same hospital.
- Outpatient bill overlaps an inpatient admission period.
- Outpatient bill for services matches another outpatient bill with a service date for the same revenue code at the same provider or under a different provider number.

Outpatient services means services for which you prepare an outpatient HUOP record from all providers.

1 - History File - Paid Claims

FIs must maintain a history file containing information about each claim processed. The file may consist of the claim or information from it. It must contain the following minimum information:

- Beneficiary HICN;
- Beneficiary name information;
- Provider identification (name or number); and
- Billing period from the claim.

Claims or claims information in the history file may be transferred to inactive files. However, the FI must have the facility to recall such claims or information if a claim for the beneficiary involving the same time period is received.

2 - History File - Pending Claims

Contractors must have controls to prevent a duplicate claim being paid while two claims are in the process within the system at the same time. This may be accomplished through a special check of in-process claims or in the history file for paid claims. The file should contain the same minimum information indicated in subsection A above. The check should be performed prior to sending the claim to CWF.

3 - Criteria for Detecting Potential Duplicates

A "potential duplicate" claim is a claim being processed which, when compared to the history or pending file, has the following characteristics:

- Match on the beneficiary information;
- Match on provider identification, and
- One day or more overlap in billing period indicated.

FIs examine and compare to the prior bill any bill that is identified as a potential duplicate. If the services (revenue or HCPCS codes) on a claim duplicate the services for the other, FIs should check the diagnosis. If the diagnosis codes are duplicates, obtain an explanation from the provider before making payment.

Required action:

Review the FI records to determine if payment has been made *or a suspected duplicate claim is in process;*

- Determine what data are needed to support payment or a cancel action on the claim;
- *In cases where payment has been made,* initiate appropriate recovery action; and
- Instruct the provider to refund to the beneficiary any Part B deductible and/or coinsurance collected, or use the indemnification process, as appropriate.

Effective for claims received on or after July 1, 2005, Medicare FIs must add an informational indicator to the Common Working File (CWF) transaction record when, as a result of an FI audit/edit or CWF reject, the FI examines what appears to be a duplicate item or service and approves it for payment. Use the following indicator:

Value 1: suspected duplicate review performed – service determined not to be a duplicate and is approved for payment

FIs will place the appropriate value in the new indicator field of the HUIP/HUOP/HUHH/HUHC record. CWF shall pass the indicator to NCH.

FIs shall not change their current editing procedures for duplicate claims.

4 - Analysis of Patterns of Duplicate Claims

The FI shall establish a system for continuing analysis of duplicate claims. This includes the systematic evaluation of returned "Medicare Summary Notices" from

beneficiaries and communications from providers indicating a duplicate payment has been made, as well as returned checks from any payee.

The FI system should provide for analyzing duplicate claim receipts to determine whether certain providers are responsible for duplicates and if so identify those providers. The FI should educate such providers to reduce the number of duplicates they submit. Should those providers continue to submit duplicate claims, the FI should initiate program integrity action.

D - Suspect Duplicates Reviewed by Carriers/DMERCs for Duplication and Appropriately Paid

Carriers and DMERCs

Effective for claims received on or after July 1, 2005, Medicare Carriers and Durable Medical Equipment Regional Carriers (DMERCs)) must add an informational indicator to the Common Working File (CWF) transaction record when, as a result of a carrier audit/edit or CWF reject, the carrier examines what appears to be a duplicate item or service and approves it for payment. Use the following indicator:

Value 1: suspected duplicate review performed – service determined not to be a duplicate and is approved for payment

Carriers and DMERCs will place the appropriate value in the new indicator field of the HUBC/HUDC record. CWF shall pass the indicator to NCH.

Carriers and DMERCs shall not change their current editing procedures for duplicate claims.